COLORADO
Department of Health Care Policy & Financing

Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)
Effective October 1, 2016

PA Forms: Available online at https://www.colorado.gov/hcpf/provider-forms
PA Requests: Colorado Pharmacy Call Center: Phone: 1-800-365-4944 Fax: 1-888-772-9696
The PDL applies to Medicaid fee-for-service members. It does not apply to members enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

Brand Name Required = BNR, Prior Authorization = PA

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred products will be approved for one year unless otherwise stated.)
ALZHEIMER'S AGENTS *Effective 4/1/2016*	**No PA Required (*Must meet eligibility criteria)** Donepezil tab Donepezil ODT Galantamine Galantamine ER Memantine	**PA Required** ARICEPT (donepezil) ARICEPT 23mg (donepezil) ARICEPT ODT (donepezil) EXELON (rivastigmine) (cap, soln. and patch) MESTINON (pyridostigmine) (tab, syrup) NAMENDA IR (memantine) NAMENDA XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE (galantamine) (tab, oral soln) RAZADYNE ER (galantamine)	***Eligibility criteria for Preferred Agents** – All preferred products will be approved without PA if the member has a diagnosis of dementia which can be verified by SMART PA. Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Members currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of dementia.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
ANTICOAGULANTS- ORAL *Effective 10/1/2016*	**No PA Required (*Must meet eligibility criteria)** Warfarin *XARELTO (rivaroxaban) (2nd line) *PRADAXA (dabigatran) (2nd line)	**PA Required** COUMADIN (warfarin) ELIQUIS (apixaban) SAVAYSA (edoxaban)	**ELIQUIS®** will be approved if: • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is need of prophylaxis for DVT following knee or hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: o The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** o The member has significant difficulty with complying with monitoring **OR** o The member is on dialysis (For members on dialysis, treatment failure with Xarelto and Pradaxa NOT required) o The member has an allergy or intolerance to warfarin **AND** • The member has failed a one month trial of Xarelto® OR Pradaxa. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) ***PRADAXA®** will be approved if: • The member is not on dialysis **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is in need of a prophylaxis of deep vein thrombosis (DVT) and pulmonary embolism (PE) following hip replacement surgery • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria:

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			○ The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** ○ The member has significant difficulty with complying with monitoring **OR** ○ The member has an allergy or intolerance to warfarin **SAVAYSA®** will be approved if all the following criteria have been met: • Member is not on dialysis **AND** • Member does not have CrCl > 95 mL/min **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: ○ The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** ○ The member has significant difficulty with complying with monitoring **OR** ○ The member has an allergy or intolerance to warfarin **AND** • The member has failed a one month trial of Xarelto® OR Pradaxa. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) ***XARELTO®** will be approved if all the following criteria have been met: • The member is not on dialysis **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is in need of a prophylaxis of DVT following knee or hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			• The member does not have a mechanical prosthetic heart valve **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: o Labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** o The member has significant difficulty with complying with monitoring **OR** o The member has an allergy or intolerance to warfarin **Grandfathering:** Members currently stabilized on a non-preferred agent can receive approval to continue on that agent for one year if medically necessary
ANTI-EMETICS *Effective 1/1/2016*	**No PA Required** Ondansetron tablets Ondansetron ODT tab Ondansetron oral solution (members under 5 years only) DICLEGIS (doxylamine/pyridoxine)	**PA Required** AKYNZEO (netupitant/palensetron) ANZEMET (dolasetron) EMEND (apepritant) KYTRIL (granisetron) SANCUSO (granisetron) VARUBI (rolapitant) ZOFRAN (ondansetron) tabs ZOFRAN (ondansetron) suspension ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	Non-preferred products will be approved for members who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Ondansetron suspension** will be approved for members < 5 years and those members ≥ 5 years of age with a feeding tube. **Diclegis** will be approved if the member has nausea and vomiting associated with **pregnancy.** **Emend** will be approved upon verification that the member is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. **Verification may be provided from the prescriber or the pharmacy.** **Emend** will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). **Verification may be provided from the prescriber or the pharmacy.**
ANTI-DEPRESSANTS **Newer Generation Antidepressants**	**No PA Required** Bupropion IR, SR, XL	**PA Required** APLENZIN ER (bupropion ER)	Non-preferred products will be approved for members who have failed treatment with three Preferred Products with exceptions for Cymbalta (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Effective 1/1/2016	Citalopram Escitalopram Fluoxetine Mirtazapine Paroxetine Sertraline Venlafaxine IR tabs Venlafaxine ER capsules	CYMBALTA (duloxetine) CELEXA (citalopram) Desvenlafaxine ER Desvenlafaxine fumarate ER Duloxetine EFFEXOR IR EFFEXOR XR FETZIMA (levomilnacipran) Fluvoxamine (generic Luvox) IRENKA (duloxetine) KHEDEZLA (desvenlafaxine base) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) Nefazodone (generic Serzone) PRISTIQ (desvenlafaxine succinate) PEXEVA (paroxetine) Paroxetine CR PAXIL CR (paroxetine controlled release) PROZAC Weekly (fluoxetine)	**Grandfathering:** Members currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.** Cymbalta or duloxetine: Members will NOT need to fail on two preferred products if the diagnosis is Diabetic Peripheral Neuropathic Pain. Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have demonstrated failure on a one month consecutive trial of two analgesic agents (e.g. acetaminophen, NSAID) at maximally tolerated doses.

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td></td><td>SARAFEM (fluoxetine)

TRINTELLIX (vortioxetine)

Venlafaxine ER tablets

VIIBRYD (vilazodone)

WELLBUTRIN IR, SR, XL (bupropion)</td><td></td></tr>
<tr><td>ANTI-HERPETIC AGENTS

Effective 1/1/2016</td><td>No PA Required

Acyclovir tablet, capsule, suspension (generic)</td><td>PA Required

FAMVIR (famciclovir)

Famcyclovir

SITAVIG (acyclovir)

VALTREX (valacyclovir)

Valacyclovir

VALCYTE (valgancyclovir)

Valgancyclovir (oral solution)

ZOVIRAX (acyclovir)</td><td>Non-preferred products will be approved for members who have failed an adequate trial with acyclovir (dose and duration) as deemed by approved compendium (see below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)

<table>
<tr><th>Indication</th><th>Adult</th><th>Pediatric</th></tr>
<tr><td>Genital herpes simplex: initial</td><td>400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.</td><td>12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.</td></tr>
<tr><td>Genital herpes simplex: episodic</td><td>400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.</td><td>12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days</td></tr>
<tr><td>Genital herpes simplex: Suppressive

An adequate trial of acyclovir for Genital Herpes Simplex</td><td>400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.</td><td>12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12 months</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th colspan="3">Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td></td><td></td><td>(Suppressive) will be one month.</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td>Genital Herpes Simplex with HIV infection: Initial or Recurrent</td><td>400 mg ORALLY 3 times daily for 5 to 14 days</td><td>< 45 kg: 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours.
Adolescents: 400 mg ORALLY twice daily for 5 to 14 days.</td></tr>
<tr><td></td><td></td><td></td><td>Genital Herpes Simplex with HIV infection: Chronic suppression</td><td>400 mg orally twice daily</td><td></td></tr>
<tr><td></td><td></td><td></td><td>Herpes labialis</td><td>400 mg orally 3 times daily for 5 to 10 days</td><td></td></tr>
<tr><td></td><td></td><td></td><td>Herpes zoster, Shingles</td><td>800 mg orally every 4 hours 5 times a day for 7 to 10 days</td><td></td></tr>
<tr><td></td><td></td><td></td><td>Herpes Zoster, Shingles with HIV infection</td><td>800 mg orally 5 times daily for 7 to 10 days</td><td></td></tr>
<tr><td></td><td></td><td></td><td>Varicella</td><td>800 mg orally 4 times a day for 5 days</td><td>2 years or older: 20 mg/kg ORALLY 4 times a day for 5 days; over 40 kg, 800 mg ORALLY 4 times a day for 5 days</td></tr>
<tr><td></td><td></td><td></td><td>Varicella with HIV infection</td><td>20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days</td><td>20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours.</td></tr>
<tr><td>ANTI-HISTAMINES

Newer Generation Antihistamines
Effective 7/1/2016</td><td>No PA Required

Cetirizine (generic OTC Zyrtec) 5mg and 10mg tab, chew tab, syrup</td><td>PA Required

ALAVERT (loratadine)

ALLEGRA (fexofenadine)</td><td colspan="3">Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for members who have failed treatment with two preferred products in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months.</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Loratadine (generic OTC Claritin) 10mg tab and syrup	CLARINEX (desloratadine) CLARITIN (loratadine) Desloratadine Fexofenadine Levocetirizine Loratadine ODT XYZAL (levocetirizine) ZYRTEC (cetirizine)	Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.
Antihistamine/Decongestant Combinations *Effective 7/1/2016*	**No PA Required**	**PA Required** ALLEGRA-D (fexofenadine/PSE) Cetirizine-D CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) Loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	
ANTI-HYPERTENSIVES **Angiotensin Receptor Blockers (ARBs)** *Effective 7/1/2016*	**No PA Required** BENICAR (olmesartan) Valsartan Irbesartan	**PA Required** ATACAND (candesartan) AVAPRO (irbesartan) Candesartan COZAAR (losartan)	Non-preferred ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Renin inhibitors and combinations will not approved in patients with diabetes. Renin inhibitors are contraindicated when used in combination with an ACE-inhibitor, ACE-inhibitor combination,

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Losartan	DIOVAN (valsartan) EDARBI (azilsartan) Eprosartan MICARDIS (telmisartan) Telmisartan TEVETEN (eprosartan)	ARB, or ARB-combination.
ARB Combinations *Effective 7/1/2016*	**No PA Required** BENICAR HCT *BNR* (olmesartan/HCTZ) DIOVAN HCT *BNR* (valsartan/HCTZ) Losartan/HCTZ	**PA Required** Amlodipine/valsartan Amlodipine/valsartan/hctz ATACAND HCT (candesartan/HCTZ) Candesartan/HCTZ AVALIDE (irbesartan/HCTZ) AZOR (amlodipine/olmesartan) EDARBYCLOR (azilsartan/chlorthalidone) Eprosartan/HCTZ EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/hctz)	

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		HYZAAR HCT (losartan/hctz) Irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) Telmisartan/HCTZ Telmisartan/amlodipine TEVETEN HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine) Valsartan/HCTZ	
Renin Inhibitors & Renin Inhibitor Combinations *Effective 7/1/2016*	**No PA Required**	**PA Required** TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	
ANTI-PLATELETS *Effective 1/1/2016*	**No PA Required** AGGRENOX (ASA/dipyridamole) ASA/dipyridamole Clopidogrel BRILINTA (tigacrelor)	**PA Required** EFFIENT (prasugrel) PLAVIX (clopidogrel) TICLID (ticlopidine) Ticlopidine ZONTIVITY (vorapaxar)	**EFFIENT®** will be approved for patients that have a contraindication or intolerable side effects to Brilinta. • EFFIENT should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke. • **Grandfathering**: Members currently stable on Effient will be granted prior authorization approval. Patients taking BRILINTA must also be taking a maintenance dose of aspirin not exceeding 100 mg/day. Ticlopidine should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			ZONTIVITY will be approved for patients with a diagnosis of myocardial infarction or peripheral artery disease without a history of stroke, transient ischemic attack, intracranial bleeding, or active pathological bleeding. Patients must also be taking aspirin and/or clopidogrel concomitantly.
ATYPICAL ANTI-PSYCHOTICS (oral) *Effective 4/1/2016*	**No PA Required**** ABILIFY *BNR* (aripiprazole) tab Aripiprazole oral solution ABILIFY ODT *BNR* (aripiprazole) Clozapine CLOZARIL (clozapine) GEODON (ziprasidone) LATUDA (lurasidone) Olanzapine Quetiapine* Risperidone Risperidone ODT RISPERDAL (risperidone) RISPERDAL M-tab (risperidone ODT)	**PA Required** Aripiprazole FANAPT (iloperidone) FAZACLO (clozapine ODT) INVEGA (paliperidone) Olanzapine ODT NUPLAZID (pimavanserin) REXULTI (brexpiprazole) RISPERDAL oral soln (risperidone) SAPHRIS (asenapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ susp (clozapine) VRAYLAR (cariprazine) ZYPREXA ZYDIS (olanzapine ODT) *** for injectable Atypical Antipsychotics please see Appendix P for criteria**	**IR quetiapine when given at sub therapeutic doses may be restricted for therapy. Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. PA will be required for quetiapine < 150mg per day except for utilization (when appropriate) in members 65 years or older.* Non-preferred products will only be approved for their FDA approved indications and age limits and only if the member has failed on three preferred products in the last 5 years. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). See Table 1. **Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent. Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. See Table 3. **New Atypical Antipsychotic prescriptions for members under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. PA approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber. Members under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.** **Grandfathering**: Members currently stabilized on a non-preferred atypical antipsychotic can receive approval to continue on that agent for two years even if the member does not meet the age, dosing or FDA approved indication requirements. **Verification may be provided from the prescriber or the pharmacy.**

<table>
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<tr><td></td><td>SEROQUEL IR*
(quetiapine)

Ziprasidone

ZYPREXA (olanzapine)</td><td></td><td>Quantity Limits: All products including preferred products will have quantity limits. In order to receive approval for off-label dosing, the member must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen. See Table 2.

Fazaclo will be approved for the treatment of schizophrenia if the member is 18 years of age or older and has tried and failed treatment with three preferred products (one of which must be generic clozapine) in the last 5 years.

Invega will be approved for the treatment of schizophrenia or schizoaffective disorder if the member is 18 years of age or older (12 years or older for schizophrenia) and has tried and failed treatment with / has had adherence issues with three preferred products in the last 5 years. A maximum of one tablet per day will be approved.

Seroquel XR will be approved if the member is 18 years of age or older, has tried and failed treatment with three preferred products in the last five years and is being treated for one of the FDA approved indications. See Table 1.

If a member has been stabilized on quetiapine for at least 30 days with a positive response but is unable to tolerate the side effects, Seroquel XR may be approved without failure of two additional agents.

Zyprexa Zydis will be approved for the treatment of schizophrenia or bipolar 1 disorder if the member is 13 years of age or older and has tried and failed treatment with three preferred products (one of which must be an olanzapine tablet) in the last 5 years.

For members that are stabilized on Zyprexa tablets with a documented need for occasional supplementation to treat acute symptoms, up to 5 tablets per month will be allowed without three product failures.

Table 1: Approved Indications
<table><tr><th>Drug</th><th>Indication</th></tr><tr><td>Fanapt®</td><td>• Acute treatment of schizophrenia in adults</td></tr></table></td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

			Fazaclo® • Treatment-resistant schizophrenia • Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder Invega® • Schizophrenia • Schizoaffective disorder Saphris® • Acute and maintenance of schizophrenia • Bipolar mania, monotherapy • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex Seroquel XR® • Treatment of schizophrenia • Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex • Adjunctive treatment of major depressive disorder (MDD) Vraylar • Schizophrenia • Bipolar (acute treatment) Table 2: Quantity Limits

Brand Name	Generic Name	Quantity Limits
Abilify	Aripiprazole	Maximum one tablet per day
	Clozapine	Maximum dosage of 900mg per day
Fazaclo	Clozapine	Maximum dosage of 900mg per day
Fanapt	Iloperidone	Maximum two tablets per day
Invega	Paliperidone	Maximum one tablet per day
Latuda	Lurasidone	Maximum one tablet per day
	Olanzapine	Maximum one tablet per day (see Zyprexa Zydis criteria for Zydis information)
	Quetiapine	Maximum three tablets per day

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

	Risperidone	Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day
Saphris	Asenapine	Maximum two tablets per day
Seroquel XR	Quetiapine XR	Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day)
	Ziprasidone	Maximum two tablets per day
Vraylar	Cariprazine	Maximum one tablet per day

Table 3: FDA Approved Dosing by Age

Drug	FDA Approved Indication	FDA Approved Age	Max FDA App'd Dose
Asenapine (Saphris®)	APPROVED FOR ADULTS ONLY		
Aripiprazole (Abilify®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia Gilles de la Tourette's syndrome	6-17 years 10-17 years 13-17 years 6-17 years	15mg/day 30mgday 30mg/day 20mg/day
Clozapine (Fazaclo®, Clozaril®)	APPROVED FOR ADULTS ONLY		
Iloperidone (Fanapt®)			
Lurasidone (Latuda®)			
Olanzapine (Zyprexa®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 13-17 years	10mg/day 10mg/day
Olanzapine (Zyprexa Zydis®)			
Paliperidone (Invega ER®)	Schizophrenia	12-17 years	12mg/day

<table>
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<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Risperidone (Risperdal®)</td><td>Autism/Psychomotor Agitation
Bipolar Disorder/Mixed Mania
Schizophrenia</td><td>5-16 years
10-17 years
13-17 years</td><td>3mg/day
6mg/day
6mg/day</td></tr>
<tr><td>Quetiapine Fumarate (Seroquel®)</td><td>Schizophrenia
Bipolar Disorder/Mixed Mania</td><td>13-17 years
10-17 years</td><td>800 mg/day
800 mg/day</td></tr>
<tr><td>Quetiapine Fumarate (Seroquel XR®)</td><td colspan="3">APPROVED FOR ADULTS ONLY</td></tr>
<tr><td>Ziprasidone (Geodon®)</td><td colspan="3">APPROVED FOR ADULTS ONLY</td></tr>
</table>
</td></tr>
<tr><td>BISPHOSPHONATES (oral)
Effective 10/1/2016</td><td>No PA Required

Alendronate (generic)
5mg,
10mg,
35mg,
70mg tablets</td><td>PA Required

ACTONEL (risedronate)

ACTONEL w/Calcium (risedronate w/calcium)

ATELVIA (risedronate)

BINOSTO (alendronate)

BONIVA (ibandronate)

DIDRONEL (etidronate)

FOSAMAX (alendronate)

alendronate oral solution

FOSAMAX plus D (alendronate w/D)

Etidronate</td><td>Non-preferred products will be approved for members who have failed treatment with at least one strength of alendronate. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

PA will be approved for etidronate in members with heterotopic ossification without treatment failure.

For members who have a low risk of fracture, prior authorization will be required for members exceeding 5 years of either a preferred or non-preferred bisphosphonate. Low risk will be defined as having an osteopenic bone mineral density (most recent T-score between -1 and -2.5) AND no history of vertebral fracture.</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
DIABETES MANAGEMENT CLASSES **Amylin** *Effective 10/1/2016*	**No PA Required (*Must meet eligibility criteria)**	**PA Required** SYMLIN (pramlintide)	Symlin® will only be approved after a member has failed a three month trial of metformin and a DPP4-inhibitor or a GLP-1 analogue. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot tolerate metformin, DPP4-inhibitor and GLP-1 analogue due to allergy, intolerable side effects, or a significant drug-drug interaction. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. PA will be approved for Symlin products for members with Diabetes Mellitus Type 1 without failed treatment
Biguanides *Effective 10/1/2016*	**No PA Required** Metformin 500mg, 850mg, 1000mg tablets Metformin ER 500mg tablets (generic Glucophage XR)	**PA Required** FORTAMET (metformin) GLUCOPHAGE (brand) (metformin) GLUCOPHAGE XR (brand) (metformin XR) GLUMETZA ER (metformin) Metformin ER 750mg Metformin ER 500 and 1000mg (generic Fortamet, generic Glumetza) RIOMET 500mg/5ml (metformin)	Non-preferred products will be approved for members who have failed treatment with two Preferred Products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Liquid metformin will be approved for members who meet one of the following: • under the age of 12 • with a feeding tube who have difficulty swallowing
DPP-4 Inhibitors *Effective 10/1/2016*	**No PA Required (*Must meet eligibility criteria)** *TRADJENTA (linagliptin)	**PA Required** Alogliptin JANUVIA (sitagliptin) NESINA (alogliptin) ONGLYZA (saxagliptin)	*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non preferred DPP-4 inhibitors will be approved after a member has failed a three month trial of metformin and Tradjenta®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), OR the

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			member cannot tolerate Tradjenta and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.
GLP-1 Analogues *Effective 10/1/2016*	**No PA Required (*Must meet eligibility criteria)** *BYETTA (exenatide) **VICTOZA (liraglutide) (second line)	**PA Required** BYDUREON (exenatide) TANZEUM (albiglutide) TRULICITY (dalaglutide)	*Approval for Byetta® requires a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. **Approval for Victoza® requires a three month trial of (or documented contraindication to) Byetta® and metformin therapy prior to initiation of therapy. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non preferred GLP-1 agonists will be approved after a member has failed a three month trial of metformin and Byetta® and Victoza®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot tolerate Byetta® or Victoza® and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.
Hypoglycemic Combinations *Effective 10/1/2016*	**No PA Required**	**PA Required** Alogliptin/metformin Alogliptin/pioglitazone ACTOPLUS MET (pioglitazone/metformin) ACTOPLUS MET XR (pioglitazone/metformin) Pioglitazone/metformin AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride)	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Pioglitazone/glimepiride Glipizide/metformin GLUCOVANCE (glyburide/metformin) Glyburide/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JENTADUETO (linagliptin/metformin) JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE (saxaglipin/metformin) METAGLIP (glipizide/metformin) OSENI (alogliptin/pioglitazone) PRANDIMET (repaglinide/metformin)	

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Repaglinide/metformin SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozen/metformin)	
Meglitinides *Effective 10/1/2016*	**No PA Required**	**PA Required** Nateglinide PRANDIN (repaglinide) Repaglinide STARLIX (nateglinide)	Non-preferred products will be approved for members who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
SGLT-2 Inhibitors *Effective 10/1/2016*	**No PA Required (*Must meet eligibility criteria)** *INVOKANA (canaglifozin)	**PA Required** FARXIGA (dapagliflozin) JARDIANCE (empagliflozin)	*Approval for Invokana® requires a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. Non-preferred SGLT-2 inhibitors will only be approved after a member has had a three month trial of metformin and failed a three month trial of Invokana®. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C $\geq$ 7%) OR the member cannot tolerate metformin and Invokana due to allergy, intolerable side effects, or a significant drug-drug interaction. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.
Thiazolidinediones *Effective 10/1/2016*	**No PA Required** Pioglitazone	**PA Required** ACTOS (pioglitazone) AVANDIA (rosiglitazone)	Non preferred DPP-4 inhibitors will be approved after a member has failed a three month trial of metformin and failed a three month trial of pioglitazone. Failure is defined as lack of efficacy (e.g., hemoglobin A1C $\geq$ 7%), OR the member cannot tolerate pioglitazone and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.
ERYTHROPOIESIS STIMULATING AGENTS *Effective 10/1/2016*	***Must meet eligibility criteria** EPOGEN (epoetin alfa)*	**PA Required** ARANESP (darbepoetin alfa)	***Eligibility Criteria for all agents in the class** Members must meet all criteria in one of the following four areas:

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		MIRCERA (methoxy peg-epoetin beta) PROCRIT (epoetin alfa)	• A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower. • A diagnosis of chronic renal failure, and hemoglobin below 10g/dL • A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic). • A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. Hemoglobin results must be from the last 30 days. Medication must be administered in the member's home or long-term care facility. **Non-preferred products:** • Same as above; **and** • Failed treatment with Epogen. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Note: The FDA has announced a risk evaluation mitigation strategy for the use of Erythropoeisis Stimulating Agents (ESAs) in patients with cancer, who are currently receiving chemotherapy, and who are experiencing chemotherapy induced anemia. Patients must receive a medication guide outlining the risks and benefits of treatment, and patient consent must be obtained before therapy. Prescribers are required to enroll and register in the ESA APPRISE Oncology program and complete training prior to prescribing ESAs to patients with cancer. For non-cancer indications, the distribution of a medication guide to the patient is the only requirement currently.**
FIBROMYALGIA AGENTS *Effective 7/1/2016*	**No PA Required** LYRICA (pregabalin) Duloxetine	**PA Required** CYMBALTA (duloxetine) SAVELLA (milnacipran)	Non-preferred agents will be approved for fibromyalgia if member has failed an adequate trial (8 weeks) of both Lyrica and duloxetine OR the member has contraindication to Lyrica and duloxetine For members with no epilepsy diagnosis in the last two years (as confirmed by SMART PA), PA will be required for LYRICA

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			prescriptions requiring more than 3 capsules per day or for prescriptions requiring doses greater than 600mg per day. Generic DULOXETINE will be approved if the member has diagnosis of fibromyalgia.
FLUOROQUINOLONE (oral) *Effective 1/1/2016*	**No PA Required** Ciprofloxacin tablet CIPRO oral suspension (<5 years old) Levofloxacin tablet	**PA Required** AVELOX (moxifloxacin) CIPRO TABLET (ciprofloxacin) FACTIVE (gemifloxacin) LEVAQUIN TABLET (levofloxacin) LEVAQUIN oral solution Levofloxacin oral solution NOROXIN (norfloxacin) Ofloxacin	Non-preferred products will be approved for members who have failed an adequate trial (7 days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) CIPRO suspension approved for members < 5 years of age without PA For members ≥ 5 years of age, CIPRO suspension will only be approved for those members who cannot swallow a whole or crushed tablet Levofloxacin solution will be approved for members who require administration via feeding tube OR who have failed an adequate trial (7 days) of ciprofloxacin suspension. (Failure is defined as: lack of efficacy, presence of feeding tube, allergy, intolerable side effects, or significant drug-drug interaction.)
GROWTH HORMONES *Effective 4/1/2016*	**No PA Required** GENOTROPIN NORDITROPIN	**PA Required** HUMATROPE NUTROPIN OMNITROPE SAIZEN SEROSTIM ZOMACTON ZORBTIVE	Non-preferred Growth Hormones will be approved if **both** of the following criteria are met: • Member failed treatment with Genotropin OR Norditropin within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Member has a qualifying diagnosis: o Prader-Willi o Chronic renal insufficiency/failure o Turner's Syndrome o Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma o Wasting associated with AIDS or cachexia o Noonan Syndrome Grandfathering: If the member has a diagnosis for short bowel syndrome OR cachexia associated with AIDS, member will be

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			grandfathered and receive approval for a non-preferred agent due to medical necessity based on FDA approved indications.
HEPATITIS C VIRUS TREATMENTS *Effective 10/1/2016*	**Must meet eligibility criteria*** **Genotype 1:** VIEKIRA PAK, XR (ombitasvir/paritaprevir/ritonavir/dasabuvir) **Genotype 2 and 3:** EPCLUSA (sofosbuvir/velpatasvir) **Genotype 4:** TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	**PA Required** DAKLINZA (daclatasvir) HARVONI (sofosbuvir/ledipasvir) OLYSIO (simeprevir) SOVALDI (sofosbuvir) ZEPATIER (elbasvir/grazoprevir)	All preferred agents will be granted prior authorization if the following criteria are met: 1. Physician attests to the member's readiness for adherence **AND** 2. Physician attests to provide SVR12 and SVR24 **AND** 3. **AND** 4. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity **AND** 5. Member is 18 years of age and older **AND** 6. Member is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). Initial pregnancy test must be performed not more than 30 days prior to beginning therapy **AND** 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment (for ribavirin containing regimens only) **AND** 8. Prescribed an infectious disease specialist, gastroenterologist, or hepatologist **OR** prescribed by any primary care provider in consultation with an infectious disease specialist, gastroenterologist or hepatologist **AND** 9. Meets one of the following categories: • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with fibrosing cholestatic HCV; • Member has cirrhosis (F4) based on: o Biopsy within 5 years; OR o FibroScan; OR o Imaging indicating definitive evidence of cirrhosis, portal hypertension, splenomegaly or history of varices or ascites; OR o Fibrometer not more than 6 months old; OR o FibroTest not more than 6 months old; OR o Shear Wave Elastography indicating cirrhosis; **OR**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

			• Member has a fibrosis score equivalent to METAVIR F2 or F3 based on:
			  o Biopsy within 5 years; OR
			  o Fibroscan; OR
			  o Imaging indicating definitive fibrosis stage 2 or 3; OR
			  o Concordance among either FibroTest (within 6 months) or FibroMeter (within 6 months) PLUS either APRI or FIB4; OR
			  o Shear Wave Elastography indicating fibrosis stage 2 or 3; **OR**
			• Member is a woman who is planning on becoming pregnant in the next year; **OR**
			• Member is post liver transplant **AND**
			10. Members must have genotyping results within one (1) year of anticipated therapy start date **AND**
			11. If member is abusing/misusing alcohol or controlled substances, they must be receiving or be enrolled in counseling or substance use treatment program for at least one month prior to starting treatment **AND**
			12. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy **AND**
			13. If the week 4 HCV RNA is detectable (>25 copies) while on therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided which supports continuation of therapy **AND**
			14. Preferred products must be prescribed in accordance with approved regimens and duration (see tables below) **OR**
			15. For non-preferred products or treatment regimens, documentation must be provided indicating rationale for not prescribing a preferred treatment regimen. (Rationale may include, for example, patient specific medical contraindications to a preferred treatment)

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
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<tr><td></td><td></td><td></td><td>
Ribavirin ineligibility criteria:

Pregnant women and men whose female partners are pregnant
Known hypersensitivity to ribavirin
Autoimmune hepatitis
Hemoglobinopathies
Creatinine Clearance < 50mL/min
Coadministered with didanosine

<u>Note</u>: The Department will only cover a once per lifetime treatment with any DAA.

<u>Refills</u>: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. Please allow ample time for reauthorization after HCV RNA levels are submitted.

<u>Treatment Readiness</u>: Prescribers should utilize assessment tools to evaluate readiness of the patient for treatment, some examples are available at: http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs or Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C) is available at: https://prepc.org/

Viekira Table:
<table>
<tr><th>Patient Population</th><th>Treatment</th><th>Duration</th></tr>
<tr><td>Members with genotype 1a, without cirrhosis</td><td>Viekira + ribavirin</td><td>12 weeks</td></tr>
<tr><td>Members with genotype 1a, treatment naive, with compensated cirrhosis</td><td>Viekira + ribavirin</td><td>12 weeks</td></tr>
<tr><td>Members with genotype 1a, treatment experienced, with compensated cirrhosis</td><td>Viekira + ribavirin</td><td>24 weeks</td></tr>
<tr><td>Members with genotype 1b, with or without cirrhosis</td><td>Viekira</td><td>12 weeks</td></tr>
<tr><td>Post-transplant members</td><td>Viekira + ribavirin</td><td>24 weeks</td></tr>
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<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td></td><td></td><td>Members must be adherent to treatment regimen, and the proCeed Nurse Connector program should be used for patients taking Viekira or Technivie (To enroll by Phone: 1-855-984-3547 or Fax: 1-866-299-1687) to re-enforce adherence. This is a free benefit for the patient and provider.

Technivie Table:<table><tr><th>Patient Population</th><th>Treatment</th><th>Duration</th></tr><tr><td>Members with genotype 4 who are treatment naïve, with or without cirrhosis</td><td>Technivie + ribavirin</td><td>12 weeks</td></tr></table>
Epclusa Table:<table><tr><th>Patient Population</th><th>Treatment</th><th>Duration</th></tr><tr><td>Members without cirrhosis and members with compensated cirrhosis</td><td>Epclusa</td><td>12 weeks</td></tr><tr><td>Members with decompensated cirrhosis</td><td>Epclusa + ribavirin</td><td>12 weeks</td></tr></table></td></tr>
<tr><td>INSULIN
Effective 4/1/2016

Rapid Acting</td><td>No PA Required

NOVOLOG vial/ pen</td><td>PA Required

AFREZZA

APIDRA all forms

HUMALOG vial/ pen/ kwikpen</td><td>Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)

AFREZZA (human insulin) will be approved for members with the following criteria:
Member is 18 years or older AND
Member has intolerable side effects or severe allergic reactions to Novolog AND
Member must not have chronic lung disease such as asthma and COPD AND
If member is a type 1 diabetic, must use in conjunction with long-acting insulin AND
Member must not be a smoker</td></tr>
<tr><td>Short Acting</td><td>HUMULIN R vial</td><td>NOVOLIN R all forms
HUMULIN R kwikpen</td><td>Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Intermediate Acting	HUMULIN N vial/ pen/ kwikpen	NOVOLIN N all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Long Acting	LEVEMIR vial/ pen *LANTUS (2nd line)	BASAGLAR (glargine) all forms TOUJEO all forms TRESIBA (degludec) all forms	Non-preferred products will be approved if the member has failed treatment with Levemir and Lantus (Failure is defined as: allergy or intolerable side effects) Lantus will be approved if the member has failed treatment with Levemir in the last month (Failure is defined as: allergy or intolerable side effects)
Mixtures	HUMULIN 70/30 vial/ pen/ kwikpen HUMALOG MIX 50/50 vial/ pen HUMALOG MIX 75/25 vial/ pen NOVOLOG MIX 70/30 vial/ pen	NOVOLIN 70/30 vial	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
INTRANASAL CORTICOSTEROIDS *Effective 4/1/2016*	**No PA Required** Fluticasone (generic FLONASE) NASONEX (mometasone)	**PA Required** BECONASE AQ (beclomethasone diproprionate) Budesonide CHILD NASACORT (triamcinolone) DYMISTA (azelastine/ fluticasone propionate) FLONASE (fluticasone) Flunisolide NASAREL (flunisolide)	Non-preferred Intranasal Corticosteroids will be approved if the member has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). • Rhinocort AQ will be approved for pregnant members without failure of preferred products. • Brand name Flonase will require a letter of medical necessity

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		NASACORT AQ (triamcinolone) OMNARIS (ciclesonide) QNASL (beclomethasone diproprionate) RHINOCORT AQ (budesonide) Triamcinolone acetonide VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	
LEUKOTRIENE MODIFIERS *Effective 4/1/2016*	**No PA Required** Montelukast (tab, chewable)	**PA Required** ACCOLATE (zafirlukast) SINGULAIR (montelukast) (tab, chewable tab) ZAFIRLUKAST ZYFLO (zileuton) ZYFLO CR (zileuton)	Non-preferred Leukotrienes will be approved if **both** of the following criteria are met: • Member failed treatment with montelukast in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Member has a diagnosis of Asthma
MULTIPLE SCLEROSIS AGENTS *Effective 4/1/2016*	**No PA Required (unless indicated)** AVONEX (interferon beta 1a) BETASERON (interferon beta 1b) *GILENYA (fingolimid) (2nd line)	**PA Required** AUBAGIO (teriflunomide) AMPYRA (dalfampridine) COPAXONE 40MG INJECTION (glatiramer) EXTAVIA (interferon beta 1b) GLATOPA (glatiramer)	Non-preferred **Interferon** products will be approved if the member has failed treatment with three preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Copaxone® 40mg will be approved for members who have a severe intolerable injection site reactions (e.g, pain requiring local anesthetic, oozing, lipoatrophy, swelling, or ulceration) to Copaxone 20mg. For treatment of EARLY disease, Gilenya will be approved for members that meet the following criteria: • Documented, diagnosis of multiple sclerosis made by neurologist in the last 3 years AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	REBIF (interferon beta 1a) COPAXONE 20MG INJECTION (glatiramer)	PLEGRIDY (peg-interferon beta 1a) TECFIDERA (dimethyl fumarate) ZINBRYTA (daclizumab)	• Documentation provided by prescribing neurologist, or is prescribed in conjunction with a neurologist, for marked functional decline as demonstrated by two of the following: o MRI, EDSS scale OR medical chart notes that specify increased burden of disease AND • Provider attests to shared decision making with respect to risks versus benefits of medical treatment AND • Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or New York Heart Association Class III-IV heart failure within six months of initiating therapy AND • Does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome unless patient has a pacemaker AND • Has a baseline QTc interval < 500 ms prior to starting therapy AND • Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND • Has no active infections AND • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy and within 3-4 months follow-up after starting therapy AND • Had baseline complete blood count with differential and liver function tests. For the treatment of <u>EARLY</u> disease, **Tecfidera** and **Aubagio** may be approved for members that meet the following criteria: • Member has failed Gilenya. Failure will be defined as intolerable side effects, drug-drug interaction, contraindication to, or lack of efficacy AND • Documented, diagnosis of multiple sclerosis made by neurologist in the last 3 years AND • Documentation provided by prescribing neurologist, or is prescribed in conjunction with a neurologist, for marked

<table>
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<tr><td></td><td></td><td></td><td>functional decline as demonstrated by two of the following: AND
o MRI, EDSS scale OR medical chart notes that specify increased burden of disease
• Provider attests to shared decision making with respect to risks versus benefits of medical treatment AND
• Appropriate safety criteria for Tecfidera and Aubagio are met below:

<table><tr><th colspan="2">Safety Criteria</th></tr><tr><th>Tecfidera</th><th>Aubagio</th></tr><tr><td>• Has no active infections AND
• Had a complete blood count with differential within the six months prior to initiating therapy</td><td>• Has no active infections AND
• If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive AND
• Had transaminase and bilirubin levels with ALT < 2 times the upper limit of normal within the 6 months prior to initiating therapy AND
• Had a complete blood count with differential within the six months prior to initiating therapy AND
• Has a documented baseline blood pressure AND
• Has been evaluated for active or latent tuberculosis infection by documented test results (purified protein derivative test) or blood test.</td></tr></table>
AUBAGIO will be approved if member met all the following criteria:
• In members without a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product AND GILENYA. [Failure will be defined as intolerable side effects drug-drug interaction, or lack of efficacy]
OR</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			• In members **with** a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy. Lack of efficacy will be defined as one of the following: • On MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy. • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist or is prescribed in conjunction with a neurologist AND • Has no active infections AND • If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive AND • Had transaminase and bilirubin levels with ALT<2 times the upper limit of normal within the 6 months prior to initiating therapy AND • Had a complete blood count with differential within the six months prior to initiating therapy AND • Has a documented baseline blood pressure AND • Has been evaluated for active or latent tuberculosis infections by documented test results (purified protein derivative test) or blood test. **TECFIDERA** will be approved if the member has met all the following criteria: • In members without a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product and GILENYA. Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy OR • In members with a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy. Lack of efficacy will be defined as one of the following: • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			• On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist or is prescribed in conjunction with a neurologist AND • Has no active infections AND • Had a complete blood count with differential within the six months prior to initiating therapy. ***GILENYA** will be approved if the member has met all the following criteria: • Has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy. Lack of efficacy will be defined as one of the following: • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist or is prescribed in conjunction with a neurologist AND • Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or New York Heat Association Class III-IV heart failure within six months of initiating therapy AND • Does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome unless patient has a pacemaker AND • Has a baseline QTc interval <500 ms prior to starting therapy AND • Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND • Has no active infections AND • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy within 3-4 months after starting therapy AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			• Had a baseline complete blood count with differential and liver function tests. **AMPYRA** – Up to a 90 day supply of Ampyra will be approved if all of the following criteria are met: • Member has a diagnosis of MS; • Member is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment; • Member has no history of seizure disorder; • Member has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min); • Prescriber is a neurologist or is prescribed in conjunction with a neurologist; • The prescribed dose does not exceed 10 mg twice daily. Extended coverage of Ampyra (up to one year) will be approved if documentation shows improvement in ambulation (measured by T25FW assessment) or improvement in ADLs after three months of therapy. Grandfathering: Members currently stabilized on GILENYA, TECFIDERA, and AUBAGIO may receive approval to continue on that agent.
OPHTHALMIC ALLERGY *Effective 4/1/2016*	**No PA Required** Cromolyn Olopatadine 0.1% PATADAY (olopatadine) PAZEO (olopatadine) ZADITOR (ketotifen)	**PA Required** ALAMAST (pemirolast) ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) Azelastine BEPREVE (bepotastine) ELESTAT (epinastine)	Non-preferred Ophthalmic Allergy medications will be approved if the member has failed treatment with two preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		EMADINE (emedastine) LASACRAFT (alcaftadine) Ketotifen OPTICROM (sodium cromoglicate) PATANOL (olopatadine)	
OPIOIDS **Long Acting – Oral Opioids** *Effective 7/1/2016*	**No PA Required** **FIRST LINE** Fentanyl patches Methadone (generic Dolophine) Morphine ER (generic MS Contin) Tramadol ER	**PA Required** BELBUCA (buprenorphine) buccal film *BUTRANS (buprenorphine) patch CONZIP (TRAMADOL ER) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) EMBEDA (morphine/naltrexone) EXALGO (hydromorphone ER) Hydromorphone ER HYSINGLA (hydrocodone ER) KADIAN (morphine ER) MS CONTIN (morphine ER) MORPHABOND (morphine ER) NUCYNTA ER (tapentadol ER)	Non-preferred, long-acting oral opioids will be approved for members who have failed treatment with two preferred agents in the last six months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Fentanyl patches (Duragesic) will require a PA for doses of more than 1 patch/2 days. *Butrans patches will be approved for members who have failed treatment with ONE preferred agent in the last 6 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) ZOHYDRO ER and HYSINGLA® ER and OXYCONTIN (new starts) will be approved for members who have failed treatment with two preferred products, AND at least one other long acting opiate in the past year. OXYCONTIN®, OPANA ER®, NUCYNTA ER®, and ZOHYDRO ER® will only be approved for twice daily dosing. HYSINGLA ER® will only be approved for once daily dosing. No more than one long-acting oral opioid will be approved at one time. Medicaid is not mandating that a patient switch from a non-preferred drug to methadone. Methadone requires special training due to its complex pharmacokinetic profile. However, if a patient has tried and

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		OPANA ER (oxymorphone ER) OXYCONTIN (oxycodone ER) XARTEMIS XR (oxycodone/acetaminophen) ZOHYDRO ER (hydrocodone ER)	failed methadone in the past, it can be considered a trial of one preferred drug. Use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of neonatal abstinence syndrome. Providers should offer access to contraceptive services when necessary. For all prior authorization requests for opiate agents, provider must attest to counseling provided to women of childbearing age. The total daily limit of milligrams of morphine equivalents is 300mg effective 2/17/2016. This includes opioid-containing products where conversion calculations are applied. Prescriptions that cause the member's drug regimen to exceed the maximum daily limit of 300 milligrams of morphine equivalents (MME) will be denied. This does not currently include methadone prescriptions. Prior authorizations will be granted to allow for tapering. • A one year PA will be granted for diagnosis of sickle cell anemia or admission to or diagnosis of hospice or end of life care. • A one year PA will be granted for pain associated with cancer. Medicaid provides guidance on the treatment of pain, including tapering, on our website Pain Management Resources and Opioid Use at www.Colorado.gov/hcpf then search Pain Management. Only one long-acting oral opioid agent (including different strengths) and one short-acting opioid agent (including different strengths) will be considered for a prior authorization.
OVERACTIVE BLADDER AGENTS *Effective 10/1/16*	**No PA Required** Oxybutynin tablets (generic) Oxybutynin ER tablets (generic)	**PA Required** DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand)	Non-preferred products will be approved for members who have failed treatment with two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	TOVIAZ (fesoterodine ER)	DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate GELNIQUE (oxbutynin gel) MYRBETRIQ (mirabegron) Oxybutynin syrup OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Tolterodine VESICARE (solifenacin)	Members with hepatic failure can receive approval to receive trospium or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.
PANCREATIC ENZYMES *Effective 1/1/2016*	**No PA Required** CREON (pancrelipase) ZENPEP (pancrelipase)	**PA Required** PANCREAZE (pancrelipase) PANCRELIPASE (pancrelipase) PERTZYE (pancrelipase) ULTRESA (pancrelipase) VIOKACE (pancreatin)	Non-preferred products will be approved for members who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.) Grandfathering: Members currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.
PROTON PUMP INHIBITORS *Effective 1/1/2016*	***Must meet eligibility criteria** NEXIUM (esomeprazole) capsules and packets **BNR**	**PA Required** ACIPHEX tab, sprinkles (rabeprazole)	*PA will be required for therapy beyond 60 days of treatment per year for all agents. For members treated for GERD, once 60 days of therapy per year has been exceeded, members must fail an adequate trial of a histamine 2 receptor antagonist (H2A) before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td>Omeprazole generic capsules

Pantoprazole tablets

PREVACID solutab BNR (lansoprazole)
(for members under 2)</td><td>DEXILANT (dexlansoprazole)

KAPIDEX (dexlansoprazole)

Esomeprazole (generic Nexium)

Esomeprazole strontium

Lansoprazole capsules

Lansoprazole 15mg OTC (currently available as PREVACID 24HR)

NEXIUM 24 hour

PREVACID (lansoprazole) capsules & suspension

PRILOSEC OTC (omeprazole)

PROTONIX (pantoprazole) tablets and suspension

Rabeprazole (generic Aciphex)

ZEGERID (omeprazole/Na bicarbonate)</td><td>histamine 2 receptor antagonist at optimal doses listed in the table below.

<table><tr><th>Drug</th><th>Optimal Dose</th></tr><tr><td>Erbrotidine</td><td>800 mg once daily</td></tr><tr><td>Famotidine</td><td>20 mg twice daily</td></tr><tr><td>Nizatidine</td><td>150 mg twice daily</td></tr><tr><td>Ranitidine</td><td>150 mg twice daily</td></tr><tr><td>Ranitidine</td><td>** For children less than 30 kg, maximum dose is 10mg/kg per day divided in 2 doses</td></tr><tr><td>Roxatidine</td><td>150 mg once daily or 75mg twice daily</td></tr></table>
Long-term therapy, without a H2A trial, will be approved for members with Barrett’s Esophagus, Erosive Esophagitis, GI Bleed, post-bariatric surgery; Hypersecretory Conditions (Zollinger Ellison), Recurrent Aspiration Syndrome, chronic NSAID or prednisone therapy, Spinal Cord Injury members with an acid reflux diagnosis, or children (< 18 years of age) with Cystic Fibrosis, on mechanical ventilation or who have a feeding tube.

In addition, members with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist will be approved for up to one year of daily PPI therapy.

Non-preferred proton pump inhibitors will be approved if all of the following criteria are met:
• Member failed treatment with three Preferred Products within the last 24 months,
• Member has a qualifying diagnosis, AND
• Member has been diagnosed by an appropriate diagnostic method.

The Qualifying Diagnoses are:
Barrett’s Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			The Appropriate Diagnostic Methods are: GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test **Quantity Limits:** Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett's Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis. **Age Limits:** Aciphex, Protonix, and Zegerid will not be approved for members less than 18 years of age. Prevacid Solutab will be approved for members less than 2 years old and ≥ 2 years with a feeding tube.
H. Pylori Treatments	NONE	OMECLAMOX-PAK (amoxicillin/ omeprazole/ clarithromycin) PREVPAC (amoxicillin/lansoprazole/ clarithromycin) Amoxicillin/lansoprazole/ clarithromycin PYLERA (bismuth subcitrate/ metronidazole/tetracycline)	H. Pylori treatments should be used as individual products unless one of the individual products is not commercially available then a PA for the combination product will be given.
PULMONARY ARTERIAL HYPERTENSION THERAPIES **Phosphodiesterase Inhibitors** *Effective 1/1/2016*	***Must meet eligibility criteria** Sildenafil **(**generic Revatio)	**PA Required** ADCIRCA (tadalafil) REVATIO (sildenafil)	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. Non-preferred products will be approved for members who have failed treatment with sildenafil. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering**: Members currently stabilized on Adcirca can receive approval to continue on that agent.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Endothelin Antagonists *Effective 1/1/2016*	***Must meet eligibility criteria** LETAIRIS (ambrisentan)	**PA Required** OPSUMIT (macitentan) TRACLEER (bosentan)	Non-preferred products will be approved for members who have failed treatment with Letairis or for members requiring a dose preparation not available with a preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.
Prostanoids *Effective 1/1/2016*	***Must meet eligibility criteria** Epoprostenol (generic) VENTAVIS (iloprost)	**PA Required** FLOLAN (brand) (epoprostenol) ORENITRAM (treprostinil) REMODULIN (treprostinil) TYVASO (treprostinil) VELETRI (epoprostenol) UPTRAVI (selexipag)	Non-preferred products will be approved for members who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction) **Grandfathering:** Members who have been previously stabilized on a non-preferred product can receive approval to continue on the medication.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Guanylate Cyclase (sGC) Stimulator *Effective 1/1/2016*		**PA Required** ADEMPAS (riociguat)	**Adempas** will be approved for patients who meet the following criteria: • Patient is not a pregnant female and is able to receive monthly pregnancy tests while taking Adempas and one month after stopping therapy. AND • Women of childbearing potential and their male partners must use one of the following contraceptive methods during treatment and one month after stopping treatment (e.g, IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method). AND • Patient is not receiving dialysis or has severe renal failure (e.g, Crcl < 15 ml/min). AND • Patient does not have severe liver impairment (e.g, Child Pugh C). AND • Prescriber must be enrolled with the Adempas REMS Program. AND • Female patients, regardless of reproductive potential, must be enrolled in the Adempas REMS program prior to starting therapy. AND • Patient has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR • Patient has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions).
RESPIRATORY INHALANTS **Inhaled Anticholinergics & Anticholinergic Combinations** *Effective 7/1/2016*	**No PA Required** **<u>Solutions</u>** Albuterol/ipratropium solution Ipratropium (generic Atrovent) solution **<u>Short-Acting Inhalers</u>** ATROVENT HFA (ipratropium)	**PA Required** **<u>Solutions</u>** ATROVENT (ipratropium) solution **<u>Short-Acting Inhalers</u>** **<u>Long-Acting Inhalers</u>** ANORO ELLIPTA (umeclininium/vilanterol)	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name PA stating medical necessity. ATROVENT® solution and DUONEB ® will require a brand-name prior authorization stating medical necessity. SPIRIVA RESPIMAT ® will be approved for members with a diagnosis of asthma requiring the use of this drug for maintenance therapy

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	COMBIVENT RESPIMAT (albuterol/ipratropium) **<u>Long-Acting Inhalers</u>** SPIRIVA Handihaler (tiotropium)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol fumarate) INCRUSE ELLIPTA (umeclindinium) SEEBRI Neohaler (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) STIOLTO Respimat (tiotropium/olodaterol) TUDORZA Pressair (aclidinium) UTIBRON Neohaler (glycopyrrolate/indacaterol)	Non-preferred anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have failed treatment with Spiriva Handihaler® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) or who have a contraindication to Spiriva Handihaler. Non-preferred combination anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema AND has failed treatment with Combivent Respimat® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction), OR who have a contraindication to Combivent Respimat®.
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists (short acting)** *Effective 7/1/2016*	**No PA Required** **<u>Solutions</u>** Albuterol (generic) solution **<u>Inhalers</u>** PROAIR (albuterol) HFA	**PA Required** **<u>Solutions</u>** Metaproterenol Levalbuterol solution PROVENTIL (albuterol) solution XOPENEX (levalbuterol) solution **<u>Inhalers</u>** Metaproterenol inhaler Pirbuterol PROAIR Respiclick PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler	Non-preferred, short acting beta2 agonists will be approved for members who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). **Proair HFA, Proventil HFA, Ventolin HFA**: Quantity limits: 2 inhalers / 30 days

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		XOPENEX (levalbuterol) Inhaler	
RESPIRATORY INHALANTS Inhaled Beta2 Agonists (long acting) *Effective 7/1/2016*	**No PA Required* (if dx restrictions met)** SEREVENT DISKUS* (salmeterol) inhaler	**PA Required** **Solutions** BROVANA (Arformoterol) solution PERFOROMIST (formoterol) solution **Inhalers** ARCAPTA (indacaterol) neohaler FORADIL (formoterol) STRIVERDI RESPIMAT (olodaterol)	SEREVENT ® will be approved for members with moderate to very severe COPD. Non-preferred agents will be approved for members with moderate to severe COPD, AND members must have failed a trial of SEREVENT (Failure is defined as: lack of efficacy, allergy, contraindication to, intolerable side effects, or significant drug-drug interaction). **For treatment of members with diagnosis of asthma needing add-on therapy, please refer to preferred agents in combination Long-Acting Beta Agonist/Inhaled Corticosteroid. SEREVENT will not be approved for treatment of asthma in members needing add-on therapy due to safety risks associated with monotherapy.
RESPIRATORY INHALANTS Inhaled Corticosteroids *Effective 7/1/2016*	**No PA Required** **Solutions** Budesonide nebules 0.25mg and 0.5mg PULMICORT (budesonide) nebules 1mg **Inhalers** ASMANEX twisthaler (mometasone) FLOVENT (fluticasone) diskus FLOVENT (fluticasone) HFA QVAR (beclomethasone)	**PA Required** **Solutions** PULMICORT (budesonide) nebules 0.25mg and 0.5mg **Inhalers** AEROSPAN HFA (flunisolide) inhaler ALVESCO (ciclesonide) inhaler ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler PULMICORT (budesonide) flexhaler	Non-preferred inhaled corticosteroids will be approved in members with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at least 6 weeks. (Failure is defined as: lack of efficacy, allergy, contraindication to, intolerable side effects, or significant drug-drug interactions.) Pulmicort Flexhaler will only be approved for female members with asthma who have a new diagnosis of pregnancy. Budesonide nebulizer solution will only be approved for a maximal dose of 2mg/day.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS Inhaled Corticosteroid Combinations *Effective 7/1/2016*	**No PA Required** ADVAIR Diskus (fluticasone/salmeterol) DULERA (mometasone/ formoterol)	**PA Required** ADVAIR HFA (fluticasone/salmeterol) BREO Ellipta (vilanterol/fluticasone furoate) SYMBICORT (budesonide/formoterol) inhaler	Non-preferred inhaled corticosteroid combinations will be approved for members meeting both of the following criteria: • Member has a qualifying diagnosis of asthma or COPD; AND • Member (with a diagnosis of asthma) has failed two preferred agents due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. Members with a diagnosis of COPD will only have to fail one preferred agent due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.
SEDATIVE- HYPNOTICS (non-benzodiazepine) *Effective 4/1/2016*	**No PA Required* (unless duplication criteria apply)** Eszopiclone Zaleplon Zolpidem	**PA Required** AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) EDLUAR (zolpidem) (sublingual) INTERMEZZO (zolpidem) (sublingual) LUNESTA (eszopiclone) ROZEREM (ramelteon) SONATA (zaleplon) ZOLPIMIST (zolpidem)	Non-preferred sedative hypnotics will be approved for members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) BELSOMRA (suvorexant) will be approved for members that meet the following criteria: • Members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • Member is not receiving strong inhibitors (e.g, erythmromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (e.g, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John's Wort) of CYP3A4 **AND** • Member does not have a diagnosis of narcolepsy Sedative hypnotics will require PA for member's ≥65 years of age exceeding 90 days of therapy. Rozerem will be approved for members with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			Children: PAs will be approved for members 18 years of age and older. ***Duplications:** Only one agent in this drug class will be approved at a time. Approval will not be granted for members currently taking a long-acting benzodiazepine such as clonazepam or temazepam.
SKELETAL MUSCLE RELAXANTS *Effective 7/1/2016*	**No PA Required (if under 65 years of age)*** Baclofen (generic Lioresal) Cyclobenzaprine (generic Flexeril) 5mg and 10mg tablet Tizanidine (generic Zanaflex) 2mg and 4mg tablet	**PA Required** AMRIX ER (cyclobenzaprine ER) Carisoprodol Chlorzoxazone Cyclobenzaprine 7.5mg tabs DANTRIUM (dantrolene) Dantrolene FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone) METAXALL (metaxolone) Metaxolone Methocarbamol Orphenadrine PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol)	All agents in this class will require a PA for members 65 years of age and older. Approval will only be given if the member has had at least a 7 day trial with an opiate or has a diagnosis of spasticity. The maximum allowable approval will be for a 7-day supply. Non-preferred skeletal muscle relaxants will be approved for members who have failed two preferred agents in the last 6-months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.) Authorization for any CARISOPRODOL product will be given for a maximum 3-week one-time authorization for members with acute, painful musculoskeletal conditions who have failed treatment with three preferred products.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		SKELAXIN (metaxalone) SOMA (carisoprodal) Tizanidine 2, 4, 6mg caps ZANAFLEX (tizanadine)	
STATINS *Effective 4/1/2016*	**No PA Required** Atorvastatin CRESTOR (rosuvastatin) Pravastatin Simvastatin*	**PA Required** ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) Lovastatin (generic Mevacor) MEVACOR (lovastatin) Pitavastatin PRAVACHOL (pravastatin) Rosuvastatin ZOCOR* (simvastatin)	Non-preferred Statin/Statin combinations will be approved if the member has failed treatment with two preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Children:** Altoprev, Advicor, Livalo and Vytorin will be approved for members 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for members 10 years of age and older. *Simvastatin 80mg dose products will only be covered for members who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in members who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication titled, "FDA Drug Safety Communication: New restrictions, contraindications and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
STATIN COMBINATIONS *Effective 4/1/2016*		ADVICOR (niacin ER / lovastatin) CAUDET (amlodipine /atorvastatin) JUVISYNC (sitagliptin/ simvastatin) LIPTRUZET (ezetimibe/ atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvastatin.)	
STIMULANTS and other ADHD agents *Effective 10/1/2016*	**No PA Required (if age, daily dose, dx restrictions met)** ADDERALL IR (mixed-amphetamine salts) ADDERALL XR *BNR* (mixed amphetamine salts ER) FOCALIN IR *BNR* (brand name dexmethylphenidate) FOCALIN XR *BNR* (dexmethylphenidate ER) Guanfacine ER Methylphenidate IR (generic Ritalin IR) Methylphenidate ER (generic Concerta)	**PA Required** ADZENYS XR ODT (amphetamine) APTENSIO XR (methylphenidate XR) CONCERTA (methylphenidate ER) D-amphetamine spansule DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) Dexmethylphenidate (generic Focalin IR) Dexmethylphenidate (generic Focalin XR)	For beneficiaries with ADD/ADHD or narcolepsy warranting treatment with a stimulant or non-stimulant (either preferred or non-preferred), a diagnosis of ADD/ADHD or narcolepsy must be documented in the beneficiaries medical record at the time of diagnosis and annually. For patients with ADD/ADHD, prior to receiving pharmacotherapy, the beneficiary must have additional documentation through a validated ADHD/ADD instrument. For beneficiaries with ADD/ADHD who are currently receiving a stimulant or non-stimulant but does not have an official diagnosis of ADD/ADHD, the beneficiary will have six months to obtain a diagnosis otherwise the medication will be discontinued. Non-preferred agents will be approved for members who have documented failure with two preferred products in the last 12 months (age six years or older) or documented failure with one preferred products in the last 12 months if ages 3 – 5 years (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). However, certain exceptions exist for Daytrana, Intuniv, Methylin solution, Quillivant XR, Nuvigil and Provigil. Please see the criteria below. **In addition:** Non-preferred agents will only be approved for FDA and official compendium indications. • Provigil will only be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder,

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	Mixed-amphetamine salts (generic Adderall IR) RITALIN IR (methylphenidate) STRATTERA (atomoxetine) *BNR* VYVANSE (lisdexamfetamine)	DYANAVEL XR solution (amphetamine) EVEKEO (amphetamine) Guanfacine ER INTUNIV (guanfacine ER) KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) Methylphenidate ER (generic Metadate CD, ER, generic Ritalin LA) METHYLIN SUSPENSION (methylphenidate) Mixed-amphetamine salts ER (generic for Adderall XR) Modafanil (generic PROVIGIL) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine liquid) PROVIGIL (modafinil) QUILLICHEW (methylphenidate) QUILLIVANT XR suspension (methylphenidate)	Traumatic Brain Injury, Multiple Sclerosis related fatigue or ADHD. Only a maximum of 400mg per day will be approved. • Nuvigil will be approved for obstructive sleep apnea/hypopnea syndrome, narcolepsy and shift work sleep disorder. Beneficiaries with ADD/ADHD must fail a 4 week trial of a preferred stimulant before the use of Nuvigil® will be approved. Only one tablet per day will be approved. • All other Non-preferred products will be approved for members with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, traumatic brain injury or severe autism. • **Daytrana, Methylin solution, Quillichew and Quillivant XR**: Members with documented difficulty swallowing that are unable to utilize alternative dosing with FOCALIN XR, VYVANSE or ADDERALL XR can receive approval without failure on preferred products. Provider must document contraindications. **And** Non-preferred agents will only be approved for FDA approved age limitations. • Provigil will be approved for members 16 years of age and older. • Nuvigil will be approved for members 17 years of age and older. • Adderall IR, Dexedrine and Dextrostat will be approved for members 3 years of age and older. • All other medications in this class will be approved for members 6 years of age and older. Below are the FDA recommended maximum daily doses:

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

RITALIN LA (methylphenidate ER (LA))

ZENZEDI (dextroamphetamine)

Drug	Maximum Daily Dose
Preferred	
ADDERALL ®	40 mg/day
ADDERALL XR®	40mg/day
AMPHETAMINE SALTS mixed	40 mg/day
DESOXYN ®	25mg/day
FOCALIN ®	20 mg/day
FOCALIN XR ®	40 mg/day
INTUNIV ER®	4 mg/day or 7mg/day > age 12
METHYLPHNIDATE IR	60 mg/day
METHYLPHNIDATE LA (ER)	60 mg/day
METHYLPHNIDATE ER	54 mg/day or 72 mg/day > age 12
RITALIN® IR	60 mg/day
RITALIN LA ®	60 mg/day
STRATTERA®	100 mg/day
VYVANSE ®	70 mg/day
Non preferred	
ADZENYS XR ODT ®	18.8mg or 12.5mg > age 12
AMPHETAMINE SALTS ER mixed	30mg/day
APTENSIO XR ®	60 mg/day
CONCERTA ER ®	54 mg/day or 72 mg/day > age 12
D-AMPHETAMINE ER spansule	40 mg/day
DESOXYN ®	25mg/day
DAYTRANA ®	30 mg/day
DEXEDRINE ®	40mg/day
DEXMETHYLPHENIDATE IR	20 mg/day
DEXMETHYLPHENIDATE ER	40 mg/day
DEXTROSTAT ®	40mg/day
DYANAVEL XR ODT ®	20 mg/day
EVEKEO ®	40 mg/day
GUANFACINE ER	4mg/day or 7mg/day > age 12
KAPVAY ER®	0.4 mg/day
METADATE CD ®	60 mg/day
METADATE ER ®	60 mg/day
METHYLIN ER ®	60 mg/day
METHYLIN SUSPENSION®	60 mg/day

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			METHYLPHENIDATE ER: 60 mg/day Modafanil: 400mg/day NUVIGIL ®: 250 mg/day PROCENTRA ®: 40 mg/day PROVIGIL ®: 400 mg/day QUILLICHEW ®: 60 mg/day QUILLIVANT XR®: 60 mg/day ZENZEDI ®: 40 mg/day
TARGETED IMMUNE MODULATORS *Effective 1/1/2016*	**No PA Required** ENBREL (etanercept) HUMIRA (adalimumab)	**PA Required** ACTEMRA (tocilizumab) CIMZIA (certolizumab) COSENTYX (secukinumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous OTEZLA (apremilast) SIMPONI (golimumab) STELARA (ustekinumab) TALTZ (ixekizumab) XELJANZ (tofacitinib) XELJANZ XR (tofacitinib) ***for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P**	**The Department would like to remind providers that many products have patient support programs that assist patients in drug administration, education, and emotional support for our member's diseases.** **Actemra** (SQ) will be approved for treatment of RA in members who have had treatment failure with at least one conventional DMARD (e.g, methotrexate, leflunomide, and sulfasalazine), Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction.) **Cimzia** (all dosage forms) will be approved for treatment of Crohn's disease in members who have had treatment failure with Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Cimzia** (all dosage forms) will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Cimzia** (all dosage forms) will be approved for treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Cosentyx** will be approved for moderate to severe plaque psoriasis in members who have tried and failed methotrexate, Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			Cosentyx will be approved for adults with psoriatic arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction). **Cosentyx** will be approved for adults with active ankyloses spondylitis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction). **Kineret** will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Kineret** will be approved without PA for members with documented neonatal-onset multisystem inflammatory disease (NOMID). **Orencia** will be approved for the treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Orencia** will be approved for the treatment juvenile idiopathic arthritis who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Otezla** will be approved for treatment of plaque psoriasis in members who have had treatment failure at least one conventional DMARD (e.g, methotrexate, leflunomide, and sulfasalazine), Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction.) **Simponi** will be approved (in combination with methotrexate) for treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			Simponi will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction). **Simponi** will be approved for treatment of ulcerative colitis in members who have tried and failed Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Stelara** will be approved with or without methotrexate for the treatment of Psoriatic Arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Stelara** will be approved for moderate to severe plaque psoriasis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Taltz** will be approved for members with diagnosis of moderate to severe plaque psoriasis who have tried and failed methotrexate, Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction) **Taltz** approval will be given for an initial 12 weeks and further authorization will be provided based on clinical response **Xeljanz** will be approved for the treatment of RA in members who have had treatment failure with methotrexate, Humira, and Enbrel (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Xeljanz** will be not be approved for combination therapy with a biologic disease modifying agent. Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
TESTOSTERONE PRODUCTS *Effective 7/1/2016*	**Must meet criteria** ANDROGEL 1.62% (testosterone topical) ANDRODERM (testosterone patch) DEPO TESTOSTERONE (testosterone cypionate) IM Testosterone Cypionate IM	**PA Required** ANDROGEL 1% **BNR** (testosterone) ANDROID (methyltestosterone) ANDROXY (fluoxymesterone) AXIRON solution (testasterone) DELATESTRYL (testosterone enanthate) IM injection FORTESTA gel (testosterone) Methyltestosterone NATESTO nasal gel (testosterone) STRIANT buccal (testosterone) TESTIM gel (testosterone) Testosterone gel TESTRED (methyltestosterone) Testosterone enanthate IM injection VOGELXO gel	*Hypogonadotropic or Primary Hypogonadism* Preferred androgenic drugs will be approved for members meeting the following: 1. Male patient > 18 years of age AND 2. Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review by a state pharmacist) AND 3. Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND 4. Does not have a diagnosis of breast or prostate cancer AND 5. Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL AND 6. Has normal liver function tests prior to initiation of therapy *Gender Transition* Preferred androgenic drugs will be approved for members meeting the following: 1. Biologically born female patient > 18 years of age* AND 2. Is undergoing female to male transition AND 3. Has a negative pregnancy test prior to initiation AND 4. Has normal liver function tests prior to initiation of therapy *For members < 18 years of age, a manual review will be required. Non-preferred androgenic drugs will be approved for patients meeting the above criteria with documented failure with an 8 week trial of a preferred androgenic drug (Failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction) **Grandfathering:** Members may be grandfathered on preferred agents without requirement of updated low serum testosterone laboratory testing that meet the following criteria: • Male patient > 18 years of age AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
			• Has at least one past documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND • Has documented diagnosis of hypogonadotropic or primary hypogonadism AND • Does not have a diagnosis of breast or prostate cancer AND • Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL AND • Has normal liver function tests prior to initiation of therapy
TOPICAL IMMUNOMODULATORS *Effective 7/1/2016*	**Must meet criteria** ELIDEL (pimecrolimus)*	**PA Required** PROTOPIC (tacrolimus) Tacroliumus (generic Protopic)	Manual review will be required for members needing ≥ 6 weeks of therapy. *ELIDEL® will only be approved for a member who had an adequate trial (e.g, one month or longer) of a topical steroid and failed treatment. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.) Tacrolimus will only be approved for a member who had an adequate trial (e.g, one month or longer) of a topical steroid and ELIDEL® and failed treatment. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.) For members under 18 years of age, must be prescribed by or in conjunction with a dermatologist.
TRIPTANS *Effective 1/1/2016*	**No PA Required (monthly quantity limits may apply)** IMITREX **BNR** (sumatriptan) nasal spray and injection Naratriptan tablets RELPAX **BNR** (eletriptan) Rizatriptan MLT tablets	**PA Required** AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX (sumatriptan) tablets MAXALT MLT tablets (rizatriptan) Maxalt tablets (rizatriptan)	Non-preferred products will be approved for members who have failed treatment with two Preferred Products within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions.) **Quantity Limits:** Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days. Axert and Relpax: Max 6 tabs / 30 days. Imitrex injection: Max 4 injectors / 30 days Maxalt: Max 12 tabs / 30 days.

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	Sumatriptan tablets	Rizatriptan tablets ONZETRA nasal powder (sumatriptan) SUMAVEL DOSEPRO (sumtriptan) TREXIMET (sumatriptan/ naproxen) Sumatriptan nasal spray and injection ZECUITY patch (sumatriptan) ZEMBRACE SYMTOUCH injection (sumatriptan) ZOMIG (zolmitriptan)	Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days. Zecuity patch: Max 4 patches /30 days